EXHIBIT 166

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

24 HOUR FITNESS WORLDWIDE, INC.,
Plaintiff, Chapter 11
Case No.:
v. 20-11558 (KBO)
CONTINENTAL CASUALTY COMPANY;
ENDURANCE AMERICAN SPECIALTY
INSURANCE COMPANY; STARR Adv. Proc. No
SURPLUS LINES INSURANCE COMPANY; 20-51051 (KBO)
ALLIANZ GLOBAL RISKS US INSURANCE
COMPANY; LIBERTY MUTUTAL INSURANCE
COMPANY; BEAZLEY-LLOYD'S
SYNDICATES 2623/623; ALLIED WORLD
NATIONAL ASSURANCE COMPANY;
QBE SPECIALTY INSURANCE COMPANY;
and GENERAL SECURITY INDEMNITY
COMPANY OF ARIZONA,

Defendants.

VIDEO DEPOSITION of ALLISON STOCK, Ph.D., MPH, MS
August 22, 2023
10:04 a.m. Eastern
DLA Piper
33 Arch Street, #26
Boston, Massachusetts 02110

Dana Welch, CSR, RPR, CRR, CRC

APPEARANCES OF COUNSEL:
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Also Present:
Geoff Bassett, Videographer

I N D E X

WITNESS:

ALLISON STOCK, M.D.

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PROCEEDINGS

THE VIDEOGRAPHER: Good morning, everyone. We are now on the record. This is tape one of the videotaped deposition of Dr. Allison Stock in the matter of the 24 Hour Fitness Worldwide versus Continental Casualty Company, et al. This is being heard before the United States Bankruptcy Court for the District of Delaware, Case Number 20-11558.

This deposition is being held at DLA Piper at 33 Arch Street in Boston, Massachusetts on August 22nd, 2023, and the time is now 10:04 a.m. Eastern Standard Time.

My name is Geoffrey Bassett, and I'm the videographer today. The court reporter is Dana Welch.

Counsel, at this time will you please introduce yourself and affiliations for the record.

MR. WEISS: David Weiss from the Reed Smith law firm on behalf of plaintiff, and I have with me Elizabeth Bowman, also from Reed Smith for the plaintiff.

MS. MANZO: Deanna Manzo, Mound Cotton Wollan & Greengrass, on behalf of Allied World

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Assurance Company.

ALLISON STOCK, M.D.

having provided proper identification, was placed under oath and testified as follows:

EXAMINATION

BY MR. WEISS:

Q. Good morning, Dr. Stock. What is your current business address?

A. 365 Canal Street, Suite 2750, New Orleans, Louisiana 70130.

Q. Do you also live in the New Orleans area?

A. I do.

Q. How many times have you given a deposition?

A. So that's a hard question for me because I'm the former corporate representative, the 30(b)(6) for the Chevron Corporation, and I was doing about 18 a year. As an expert probably 40ish.

Q. In the past 12 moths, approximately how many expert depositions have you given?

A. I would have to look at the history. In some of those, I am defunct company 30(b)(6)s that are listed on that testimony history, so I'd have to go through and figure out where I'm a

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00:25:11 incredibly high value of deposit of virus onto
00:25:16 these surfaces like steel or cardboard and this
00:25:22 is what happens in a real world setting when you
00:25:24 set it out on a counter.
00:25:27 Q. Okay. And this particular study that's
00:25:31 reflected in this article related to the variant
00:25:39 of SARS-CoV-2 that was circulating in the 2022
00:25:46 time period, correct?
00:25:47 A. That is correct.
00:25:50 Q. Okay. And so this -- and do you -- and
00:25:53 in the studies that were looked at previously
00:25:58 related to prior variants of the virus; is that
00:26:03 right?
00:26:03 A. That is correct.
00:26:12 Q. And in fact, I'll read on page 739 of the
00:26:16 article, under Conclusions, Strains and
00:26:21 Limitations it says, "Moreover, the initial
00:26:25 studies on SARS-CoV-2 contamination of inanimate
00:26:29 surfaces were performed early in the course of
00:26:33 the pandemic before the appearance of VOCs, and
00:26:39 thus, this study, which was designed at a time in
00:26:41 which omicron subvariants prevailed, represents a
00:26:45 significant new addition to the field."
00:26:47 Do you see that?
00:26:48 A. I do.

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00:26:50 Q. Is VOCs, does that stand for variants of
00:26:54 concern?
00:26:55 A. Yes.
00:26:58 Q. So at the time that 24 Hour Fitness
00:27:03 closed its clubs in or around March of 2020, the
00:27:10 variants that were being studied in this study
00:27:15 and reflected in this article would not have been
00:27:17 the same variants that were circulating then,
00:27:21 correct?
00:27:23 A. So in March 2020 and April 2020, there
00:27:29 were two to three different strains coming from
00:27:33 very distinct populations that we considered to
00:27:36 be alpha, if you want to think of in terms of the
00:27:39 Greek alphabet, those were sort of the earlier
00:27:42 strains.
00:27:45 Q. Okay. Are you aware of a study that
00:27:49 looked at contamination at a department store and
00:27:57 at an apartment where people were living?
00:28:01 A. Yes.
00:28:01 Q. Okay. Did you cite that study in your
00:28:08 report?
00:28:09 A. I probably didn't cite those because that
00:28:16 data was unclear in those studies of what it was
00:28:18 really -- on what the big issues were.
00:28:30 Q. Okay. And do you recall that in that

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00:28:32 particular study they concluded that the virus
00:28:41 could persist on surfaces for upwards of, I think
00:28:45 it was, 57 days?
00:28:47 A. So the problem with that study, if we're
00:28:49 talking about the same one, is they did not
00:28:51 culture the virus to see if it would infect
00:28:57 cells, and the virus is -- has a membrane that's
00:29:02 composed of fats and protein and water and it
00:29:06 readily breaks down outside of a host.
00:29:11 So while we might find a viral fragment
00:29:13 just like on the Diamond Princess cruise ship,
00:29:15 we're not finding intact virus that can make
00:29:19 people sick.
00:29:24 Q. So it's not the case that the virus that
00:29:37 they found would not infect cells, they just
00:29:41 didn't do the extra step to make that
00:29:44 determination?
00:29:46 A. So I think it's really important when
00:29:47 we're talking about viruses and the environment,
00:29:52 that viruss are ubiquitous in the environment.
00:29:54 We're going to find viral fragments to
00:29:56 everything. We're not all sick from those
00:29:58 viruses for that reason.
00:30:00 So even though we have a PCR test that
00:30:04 shows that there may have been the presence of

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00:30:05 the virus there, it does not mean that that's
00:30:09 going to get anyone ill from that virus.
00:30:13 Q. So your criticism of that prior study is
00:30:15 that they didn't culture the virus that they
00:30:18 found, correct?
00:30:20 A. All they found were viral fragments, so I
00:30:22 think we need to be very clear about what was
00:30:24 found and not found. And when we find fragments,
00:30:27 it just tells us at some point there was someone
00:30:30 who brought that in, either from them shedding it
00:30:33 themselves or on their clothing or their shoes or
00:30:35 whatever.
00:30:36 Q. Okay.
00:30:37 A. And the studies that we have after that
00:30:39 don't find live virus.
00:30:55 Q. The other -- some of the other articles
00:30:57 that you provided yesterday involve outbreaks at
00:31:02 fitness clubs; is that right?
00:31:04 A. That is correct.
00:31:05 Q. Is there a reason why those were
00:31:08 provided?
00:31:10 A. I was thinking about my -- what was the
00:31:14 basis of my opinion on those, and why I didn't
00:31:17 include those within the report. And that's
00:31:23 information that is not necessarily tied directly

00:36:38 in litigation?
00:36:39 A. Less than 50 percent, and it depends on
00:36:41 the months. Some months it's 30/70, some it's
00:36:44 50/50, and some months, given to whatever the
00:36:48 court has going on, it can be 60/40.
00:36:52 Q. Okay. At the present time, how would you
00:36:55 break it down?
00:36:56 A. It's less than 50 percent.
00:37:04 Q. And as part of your work, have you
00:37:08 engaged in providing seminars for insurance
00:37:11 companies?
00:37:13 A. So our corporation does, and I
00:37:15 occasionally am asked to speak at those.
00:37:18 Q. Have you spoken at any seminars for
00:37:21 insurance company clients related to COVID-19?
00:37:26 A. So it wasn't -- we've provided seminars.
00:37:31 It was not just solely for insurance. It was for
00:37:33 any of our clients to come to that. So some of
00:37:36 my private clients came to theirs, but we had
00:37:39 early on a seminar that was set up with a couple
00:37:41 of people giving information on COVID.
00:37:46 Q. Approximately how many seminars have you
00:37:49 participated in as a speaker that provided
00:37:53 information regarding COVID?
00:37:56 A. There was one kind of canned talk that

00:37:59 four of us gave, and it was three to four of us,
00:38:01 and I probably gave it three to four times.
00:38:03 Q. Okay. During what period of time?
00:38:09 A. We put the presentation together in April
00:38:13 of 2020 and so we probably gave it till maybe
00:38:19 October -- at least I stopped by October of 2020
00:38:22 being involved.
00:38:25 Q. Okay. And was there a reason why you
00:38:27 stopped being involved?
00:38:28 A. Because I had other work outside of this
00:38:33 type of litigation and I needed to focus on my
00:38:36 other clients.
(Exhibit 2, "Coronavirus Assessments: The Science of Transmission & Spread" webinar, marked for identification.)
00:39:26 Q. I've had marked as Exhibit 2 a printout
00:39:32 from the Internet regarding a webinar titled
00:39:40 "Coronavirus Assessments, the Science of
00:39:42 Transmission and Spread," with a date of
00:39:46 April 23rd, 2020. And it was -- it indicates
00:39:53 that it was given to the Pennsylvania Association
00:39:56 of Mutual Insurance Companies.
00:39:59 And do you have this in front of you?
00:40:00 A. I do.
00:40:02 Q. Do you recall participating in a webinar

00:40:05 for the Pennsylvania Association of Mutual
00:40:08 Insurance Companies in April of 2020?
00:40:11 A. So what I can tell you about is they
00:40:13 weren't the only group that was invited to this
00:40:15 webinar. So we had multiple different groups
00:40:18 that had asked for information on COVID. So each
00:40:22 one had their own way into it, but we all gave it
00:40:25 at one time.
00:40:26 Q. Okay. So were they -- was the -- I'll
00:40:32 call it PAMIC, were they a sponsor for this
00:40:36 webinar?
00:40:37 A. No. We don't -- well, I guess they could
00:40:38 be a sponsor because they asked us to do it, but
00:40:41 there was no payment or any of that type of
00:40:44 thing.
00:40:45 Q. Okay. And do you recall generally what
00:40:49 you talked about during this seminar?
00:40:51 A. Yes.
00:40:53 So the seminar was given by Tracey Dodd,
00:40:57 who did the beginning piece on insurance stuff.
00:41:03 I talked about what we knew about transmission.
00:41:09 Sara Raley and Eloy talked about preparing your
00:41:15 building for shutdown and what it would cost for
00:41:20 cleaning and those kinds of things and how to do
00:41:22 an invoice review if you brought someone in to

00:41:25 clean a facility because of COVID.
(Exhibit 3, J.S. Held webinar slides, marked for identification.)
00:42:05 Q. Do you recognize Exhibit 3?
00:42:07 A. I do.
00:42:07 Q. Okay. Can you describe generally what it
00:42:11 is?
00:42:11 A. Well, these are the slides from the
00:42:13 webinar that were not supposed to have been
00:42:14 distributed, but yes, these are the slides from
00:42:17 the webinar.
00:42:18 Q. Okay. And why were these not supposed to
00:42:22 be distributed?
00:42:23 A. Because at least the information that I
00:42:26 was giving to my clients at the time, I wanted to
00:42:34 make sure that we were giving the most accurate
00:42:37 information. And because information on COVID
00:42:39 was rapidly changing, we were putting out -- this
00:42:44 kept getting updated.
00:42:47 Q. Okay. Do you believe that the slides
00:42:51 conveyed accurate information at least as of the
00:42:54 date that they were presented?
00:42:57 MS. MANZO: Objection to form.
00:42:59 A. As much as we can at that time.
00:43:05 Q. Did you participate in preparing the

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00:49:41 way' in multiple regions."
00:49:44 Are you comfortable with that definition?
00:49:48 A. Well, it's not just for viruses at CDC,
00:49:51 it's for anything, any disease or any process.
00:49:54 And as I pointed out when I gave the slide, it
00:49:56 can mean that your left middle toe is blue, and
00:50:01 so long as that's going across multiple countries
00:50:04 and multiple locations and it spreads in an
00:50:06 efficient manner, it would be deemed a pandemic.
00:50:11 Q. Okay. But it also applies to viruses?
00:50:14 A. It applies to any infectious disease.
00:50:18 Q. Then in the next slide, "COVID-19, Who do
00:50:21 we rely on?"
00:50:22 What were you trying to convey there?
00:50:25 A. There is at the beginning of the pandemic
00:50:30 an incredible amount of misinformation and we
00:50:33 still see misinformation on a daily basis. And
00:50:38 so one of the things that I am very passionate
00:50:43 about as a public health practitioner is that you
00:50:46 have to go to reliable sources. Don't go to the
00:50:49 New York Times, don't go to Fox News, go to the
00:50:51 sources themselves and see what they are actually
00:50:55 saying about the disease.
00:50:57 So in this case of the pandemic, it was
00:50:59 the World Health Organization, it was the U.S.

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00:51:03 Centers for Disease Control and Prevention, CDC,
00:51:07 the EPA. EPA had great lines on cleaning. FDA
00:51:13 had great information on the drugs that were
00:51:16 available, so don't go take the malaria drug or
00:51:19 inject bleach. If you think you have COVID, go
00:51:22 to see what the FDA is saying to do.
00:51:24 And then most federal and state -- or
00:51:28 most federal, state, and community regulatory
00:51:32 governments such as the county or a parish or a
00:51:34 big city also had great information that they
00:51:37 were putting out.
00:51:39 Q. And OSHA, what about them?
00:51:42 A. OSHA had a lot of information, and
00:51:46 actually on their website, especially by job
00:51:49 title, they had risk matrices of what was
00:51:51 considered a high risk, a medium risk or low risk
00:51:53 job. And it ease really important to remember
00:51:56 that OSHA early on declared COVID-19 as a
00:51:59 reportable and recordable disease.
00:52:02 Q. Okay. And then when you say in red "Be
00:52:06 careful who you rely on," is that basically the
00:52:09 point you just made?
00:52:11 A. Don't go to Fox News, don't go to the New
00:52:12 York Times, go to the sources.
00:52:36 Q. There's a slide on the next page,

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00:52:40 "COVID-19, What are the issues our clients are
00:52:42 dealing with?"
00:52:43 Do you see that?
00:52:44 A. Yes.
00:52:44 Which one?
00:52:45 Q. The second one.
00:52:46 A. Okay.
00:52:49 Q. There's something referenced as the
00:52:51 "J.S. Held 360 virtual inspection tool to allow
00:52:55 to best review while safely away from the site."
00:52:59 Do you see that?
00:53:00 A. Yes.
00:53:00 Q. Are you familiar with what that is?
00:53:03 A. I am.
00:53:03 Q. What is that?
00:53:07 A. It's something our building consultants
00:53:09 use all the time. I used it during writing
00:53:16 reopening plans so that we had a captured video
00:53:20 of those rooms and people knew where things were
00:53:23 exactly supposed to go outside of just a drawing.
00:53:27 It's basically a 360 camera, and if you sync your
00:53:34 iPad with it remotely, you can see the whole
00:53:37 space.
00:53:38 And we had -- many of our clients and
00:53:44 many of our staff are people that were considered

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00:53:47 high risk for COVID.
00:53:48 Q. And so how would using that virtual tool
00:53:53 keep people safe?
00:53:55 A. Well, we had individuals that were obese,
00:54:00 had underlying -- other underlying health
00:54:02 conditions, and refused to wear respiratory
00:54:05 protection, and so, because I also sit on our
00:54:09 corporate safety committee, we would say you have
00:54:12 to use the tool unless you're going to wear the
00:54:14 respirator when you go into the field. We're not
00:54:16 taking on the liability of you becoming an
00:54:18 occupationally-related illness case.
00:54:21 Q. And would the people -- so somebody would
00:54:24 have to physically go into the location with the
00:54:26 camera, and would that person be also wearing a
00:54:30 respirator?
00:54:31 A. Well, they would be wearing a mask of
00:54:34 some sort of face covering. And some of them,
00:54:37 depending on where they went, it was required
00:54:39 that they wear a respirator because we did a lot
00:54:41 of work for hospitals. And those requirements
00:54:45 were different than let's say going into a
00:54:48 university.
00:54:57 Q. Under the next slide, the third slide on
00:55:00 the page, "COVID-19, What are the issues our

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01:06:25 A. So we wanted everyone to know that there
01:06:28 were going to be new technologies coming out that
01:06:31 you can either get through your doctor's office
01:06:33 or even the home kits. By April of that year,
01:06:37 there was the a -- there's a rapid analyzer that
01:06:42 your healthcare provider can do, and so that test
01:06:49 was starting to be approved so that you could go
01:06:52 to any hospital lab and they could run the test
01:06:56 very quickly versus having to wait for a PCR
01:07:00 test.
01:07:01 Q. And prior to April when that test that
01:07:04 you just described was approved, how would
01:07:07 somebody be able to confirm whether they had
01:07:11 COVID?
01:07:13 A. PCR testing.
01:07:14 Q. And what is PCR testing?
01:07:17 A. Polymerized chain reaction testing. It's
01:07:19 sort of the gold standard for COVID. The problem
01:07:21 with it is it doesn't measure intact virus. It
01:07:24 only measures a fragment of the viral RNA. And
01:07:30 for people when we do it, we take a nasal swab,
01:07:33 the hospital lab has the ability to do this. And
01:07:39 it's the sort of gold standard of measurement
01:07:43 because it's able to kind of estimate the number
01:07:46 of virons or pieces, like intact virus that you

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01:07:50 have in your body.
01:07:54 Q. Was there a time period when the
01:08:00 government required that any COVID testing be
01:08:04 done at a CDC laboratory?
01:08:08 A. So in the very early days of January,
01:08:12 that was the case. After that it was being
01:08:16 rolled out to health departments, and the health
01:08:19 departments then rolled it to healthcare
01:08:22 providers.
01:08:22 Q. Okay.
01:08:23 A. So by March, healthcare providers had the
01:08:26 ability to do the test.
01:08:30 Q. Do you remember by when in March they
01:08:32 were able to do that?
01:08:34 A. From my remembering of this, it depended
01:08:37 on the state health department and what their
01:08:38 laboratory capabilities were and how they could
01:08:40 roll it out.
01:08:51 Q. And up until then it had to go to the
01:08:56 CDC?
01:08:58 A. No. Because they -- so I think there's a
01:09:01 misconnect -- understanding of what CDC and how
01:09:05 CDC does this type of rollout of a test. In
01:09:13 January -- actually, in December when CD
01:09:18 recognized that there was this issue going on,

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01:09:20 they very quickly pulled together a team of
01:09:23 experts from the CDC and state health
01:09:26 departments, they created a method, they rolled
01:09:28 that method out to state health departments.
01:09:33 However, in those first cases in January
01:09:36 of 2020, CDC was doing confirmation, so the state
01:09:41 health department was running the test and so had
01:09:43 an answer. CDC was also running the test and
01:09:46 they were doing comparison of the tests. It's
01:09:48 very common, called "a round-robin."
01:09:51 But by March almost every place was able
01:09:54 to do the test without having to have CDC
01:09:57 confirmation.
01:09:58 Q. Was there a period of time when the
01:10:02 people who could get tested was limited, for
01:10:05 example, to people who had traveled to China or
01:10:09 people who had come into contact with people who
01:10:12 went to China, that sort of thing?
01:10:15 A. That was in January and February, and it
01:10:19 was done through the quarantine officers at the
01:10:23 different airport locations.
01:10:26 Q. So in January and February of 2020,
01:10:32 people could not get tested unless they fit
01:10:35 within those criteria?
01:10:40 A. So in January and February, there was a

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01:10:46 push by the state health departments to get it
01:10:51 rolled out at the state level, and the
01:10:55 round-robin was still going on, and they were
01:10:57 being selective of who they tested because early
01:11:01 transmission in the U.S. was very travel related
01:11:05 and not just from China, but did I travel to a
01:11:10 location where there was somebody who had been
01:11:12 from China at that location, or Italy. China was
01:11:16 not the only location. But had I come in contact
01:11:19 with someone who had been in one of these hot
01:11:23 beds outside the U.S. of COVID, or was I working
01:11:26 in a healthcare setting or some other ones like
01:11:30 that.
01:11:30 Q. And that's why the testing criteria was
01:11:33 limited?
01:11:34 A. The testing criteria wasn't limited. The
01:11:38 ability of having those institutions ready and
01:11:43 having it confirm was more limited. But on top
01:11:48 of that, there needed to be time for the primer
01:11:50 to be made for the test.
01:11:52 So CDC was and all these other
01:11:54 institutions were actively trying to make enough
01:11:56 primer so that by when we started seeing more
01:11:59 cases, they could go -- they could do the test.
01:12:02 MS. MANZO: Do you think it's a good

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01:17:38 the virus, and how expert testimony can help your
01:17:43 COVID-19 claim."
01:17:45 Do you see that?
01:17:47 A. I do.
01:17:47 Q. Did you provide any information on that
01:17:50 last point, "How expert testimony can help your
01:17:53 COVID-19 claim"?
01:17:55 A. No. That was Alycen's realm, not mine.
01:18:00 Q. Did you have a PowerPoint presentation
01:18:03 that you used for this webinar?
01:18:06 A. It's the same one we've just looked at in
01:18:07 Exhibit 3.
01:18:09 Q. Was it updated at all?
01:18:11 A. It was updated on the slides I gave and
01:18:13 then Alycen added her own slides.
01:18:15 Q. Okay. Do you still have a copy of that
01:18:19 in your files?
01:18:22 A. I don't think so, but I can double-check.
01:18:29 Q. On the second page of the exhibit,
01:18:34 there's a number of bullet points, and one of
01:18:37 them is "The differences between cleaning and
01:18:41 decontamination"?
01:18:42 A. Yes.
01:18:43 Q. Was that a topic that you covered at the
01:18:46 webinar?

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01:18:47 A. Yes.
01:18:48 Q. And what -- in general, what did you
01:18:52 discuss in that topic?
01:18:58 A. So people forget that if a surface is
01:19:01 really dirty, you can't effectively decontaminate
01:19:08 or remove, say, hepatitis-A is the easiest one,
01:19:13 actually, Norovirus is the best one, let's go
01:19:15 with that. If you -- if you come back and just
01:19:20 wipe something for Norovirus without having the
01:19:23 appropriate cleaner that would break down
01:19:27 Norovirus, it's not going to do anything. And if
01:19:29 it's surface that's really dirty, like a daycare
01:19:32 table where kids have been doing an activity,
01:19:35 you're going to have to come back and clean
01:19:37 first, so remove the debris, and then come back
01:19:40 with the appropriate cleaner to decontaminate or
01:19:43 remove or break down the virus that may still be
01:19:46 there.
01:19:47 Q. Would the same recommendation apply to a
01:19:52 coronavirus like SARS-CoV-2?
01:19:55 A. So it was part of CDC's recommendations
01:19:57 that if a surface was dirty, clean it first and
01:20:00 then do the disinfecting step next.
01:21:12 Q. When do you recall first being contacted
01:21:17 by the insurers or their counsel in this case to

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01:21:21 provide services?
01:21:23 A. Based on the job number, it would have
01:21:27 been mid portion of 2022.
01:21:34 Q. Do you recall what month you were
01:21:38 contacted in?
01:21:40 A. I can't remember.
01:21:43 Q. The engagement letter that you've
01:21:46 provided, I think is dated in October of 2022,
01:21:50 would it have been around that time?
01:21:53 A. Yes. It may have been -- I may have
01:21:55 gotten a phone call around September and then we
01:21:57 moved forward.
01:22:00 Q. Do you recall who first contacted you on
01:22:03 behalf of the insurance companies?
01:22:05 A. Mr. Ingerman.
01:22:08 Q. Had you worked with Mr. Ingerman before
01:22:11 on any case?
01:22:12 A. Yes.
01:22:14 Q. Was that a COVID case?
01:22:16 A. Yes.
01:22:17 Q. Which case was that?
01:22:20 A. I have a confidentiality agreement, so
01:22:22 I'm not able to share too much about it, but it
01:22:24 was a case related to an orthodontist office.
01:22:28 Q. Is that a case that's in litigation?

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01:22:32 A. It is.
01:22:34 Q. Is the litigation still going on?
01:22:38 A. I have no idea.
01:22:40 Q. Did you provide a report?
01:22:43 A. I did.
01:22:44 Q. Did you -- do you recall when you
01:22:46 provided the report?
01:22:50 A. It was -- I can't remember.
01:22:53 Q. Do you recall what year?
01:22:56 A. I'm struggling with that. I can't
01:22:57 remember if it was the fall of 2020 or if it was
01:22:59 the spring of -- or if it was during 2021, I'm
01:23:03 not sure.
01:23:05 Q. Do you know what court the case is
01:23:08 pending in?
01:23:09 A. I don't have that information.
01:23:11 Q. Did you give a deposition?
01:23:12 A. No, sir.
01:23:17 Q. Do you know the status of the case?
01:23:19 A. No, sir.
01:23:21 Q. Other than that case, had you worked with
01:23:23 Mr. Ingerman before?
01:23:25 A. I have one other case with him, and I'm
01:23:27 not sure of the timing.
01:23:29 Q. Is that also a COVID case?

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02:14:23 test, were recommendations made for them to stay
02:14:27 at home or to isolate or to take other
02:14:29 precautions?
02:14:31 A. So the thing that we've always said,
02:14:34 because you also have to remember that it was a
02:14:36 bad flu year in 2020 and March is still flu
02:14:40 season, we also had RSV that was out and we had
02:14:44 COVID. So in the early days, if -- my policy has
02:14:49 always been to tell my clients if somebody is
02:14:51 sick, they need to stay home. I don't care if
02:14:53 it's COVID or not, they shouldn't be there
02:14:55 hacking on somebody else and getting them
02:14:57 potentially sick with RSV or something that's
02:15:00 just as bad.
02:15:16 Q. With regard to these investigations that
02:15:19 you conducted during the pandemic, did you
02:15:23 actually go on site to your clients, or were they
02:15:29 remote?
02:15:32 A. For a lot of my clients it was on site.
02:15:34 I was an anxious traveler, and so -- and I have a
02:15:39 child with an underlying heart condition, so.
02:15:41 Q. I'm sorry.
02:15:42 A. That's okay, but thank you. She's 17,
02:15:44 she's great, and plays sports and all that other
02:15:47 good stuff.

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02:15:47 But she was at higher risk. So I was
02:15:49 very careful about where I went. And if could do
02:15:52 things as much remotely as I could using that
02:15:55 J.S. Held 360 camera, I did. But if I
02:15:59 couldn't -- but if it wasn't going to work, I
02:16:01 went on site.
02:16:01 Q. When you went on site, did you wear any
02:16:04 protective PPE?
02:16:07 A. I wore a KN-95, and I've testified in
02:16:10 court even wearing a KN-95 because of my child.
02:16:36 Q. Okay. When you went on -- when you
02:16:39 conducted on-site investigations, either you
02:16:43 personally or with your -- with staff, did you do
02:16:47 any testing of surfaces or air within facilities
02:16:52 as part of this work?
02:16:54 A. We used the luminometer early on, and
02:16:57 some of these facilities, especially our food
02:16:59 manufacturing facilities, because even though we
02:17:03 kept saying that COVID is not transmitted by
02:17:05 food, there was still concern on the part of the
02:17:09 client, so we did do the luminometer there and
02:17:14 recommend to them to use that.
02:17:18 Q. Was there any air testing that you could
02:17:20 have done at that time to test the air to see if
02:17:23 there were -- there was virus in the air?

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02:17:27 A. We didn't recommend it. It wasn't going
02:17:29 to add that much to the pieces of information we
02:17:33 needed.
02:17:34 Q. Why not?
02:17:37 A. So we knew fairly early on, and if you
02:17:40 want to look into the literature, by November of
02:17:42 2020 but even prior to that, there was
02:17:45 indications that this virus just isn't stable
02:17:49 outside of the body for a really long -- its host
02:17:52 for a long period of time.
02:17:56 Now, I have to qualify that by saying
02:17:58 that it has to be based on viral load and all of
02:18:02 those kinds of pieces that go with it, but we
02:18:05 knew that it didn't like sunlight. We knew that
02:18:09 it didn't like changes in temperature. And we
02:18:11 knew that it didn't like changes in humidity.
02:18:14 So our recommendation to our clients was
02:18:18 to because of that increase their air flow,
02:18:22 follow ASHRAE standards, and if you're able to,
02:18:29 make sure that you can just social distance or
02:18:34 physically distance the people that are in your
02:18:36 facility.
02:18:39 Q. And the recommendation for distancing
02:18:42 people was because of the -- what you referred to
02:18:45 as the primary route of transmission would be

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02:18:48 through droplets?
02:18:49 A. It's a larger, heavily droplet -- larger,
02:18:51 heavy droplets.
02:18:52 Q. Okay.
02:18:57 MR. WEISS: Why don't we go off the
02:18:58 record for a second.
02:19:00 THE VIDEOGRAPHER: The time is now 12:31.
02:19:03 Off the record.
(Proceedings interrupted at 12:31 p.m. and reconvened at 1:27 p.m.)
02:19:05 THE VIDEOGRAPHER: The time is now 1:27
02:19:10 and we are on the record.
BY MR. WEISS:
02:19:11 Q. Dr. Stock, before the break we were
02:19:13 looking at your report, which is Exhibit 6.
02:19:22 First off, are you aware of any opinions
02:19:27 that you plan to testify to at trial that are not
02:19:31 set out in your report?
02:19:36 A. The only thing that I might testify to is
02:19:38 if there is new information or if there's
02:19:41 something very specific, there's a new question
02:19:43 that's posed to me between now and then. So
02:19:47 there's like the Samnertino article, which has
02:19:50 come out when this report was written.
02:20:05 Q. And that's the article we looked at

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somebody who's COVID positive does not mean that I am at risk of getting COVID. So I want to know where they were, who they interacted with, how long they were there, and what areas within that facility did they go to.

Q. And do you know if any of the insurance companies advised 24 Hour Fitness that that was the type of information they needed to collect?

A. I have no idea about those conversations.

Q. All right. And when you say "24 Hour has not presented the data necessary to validate whether there were true cases (confirmed) of COVID-19 on 24 Hour properties," what do you mean there by a true or confirmed case?

A. So confirmed case, if you use the definition that's been set up by CSTE and CDC, tells you that you have to have the positive test and they want you to have the symptoms, or you have to have the gold standard, which is PCR.

Q. So when you say a positive test plus symptoms, what type of test are you talking about there?

A. So I'm talking about that you want to have the positive PCR test to make sure that you have truly someone who is COVID positive. You

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have to remember that the symptomatology of COVID is not specific to COVID.

Q. And can you elaborate and explain that?

A. Pardon?

Q. Can you explain what you mean by "the symptomatology of COVID is not specific to COVID"?

A. Lots of viral illnesses cause cough. Lots of viral illnesses cause fever. Lots of viral illnesses cause other symptoms that people think about with COVID, malaise, headache, sore throat. All those can be attributed to other viruses.

The other thing is one of the hallmarks that was originally proposed earlier on was this loss of taste or smell. However, what we are learning is that it's not always accurate because if you have let's say an acute case of sinusitis, you're also going to have a loss of taste or smell.

So there are other things other than saying, hey, Bob called in and he's sick to indicate that it was COVID or not. You really need that test to confirm that it is truly COVID.

Q. So during the period of January to mid

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March of 2020, if Bob called in to 24 Hour Fitness and said he was sick, how would 24 Hour Fitness go about determining if they could get a PCR test result from Bob?

A. Bob, did you go to doctor? Did you get a test? What did the test tell you?

Q. Okay. And during that time could Bob go to the doctor and easily get a PCR test?

A. In the first part of March it was a lot easier to do it than let's say January because we didn't have any cases here in the U.S. really until the first part to mid part of January.

Q. And in February?

A. We were starting to see more travel-related cases depending on what location and the country you were in. So it was still a little more difficult, but by around the beginning of March we were starting to make sure that health departments and local providers had that ability to conduct those tests.

Q. So in your opinion, in order for 24 Hour Fitness to have demonstrated that there were true cases of COVID-19 at its properties, it would need to show a positive PCR test result from somebody who was on their property?

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A. And it would have to have the right timing for COVID, and you'd want to make sure that they really were there and if you could check your log records and see. And say, you know, Bob, did you have -- did your doctor do a COVID test? Yes. What was the result? Those early days, especially in March, they were almost all going to be PCR tests except for a few antibody tests that remained then.

Q. And where were the antibody tests being done?

A. So there were pop-up laboratories across the United States that were experimenting with different tests. They weren't necessarily valid. That's why CSTE says we need that gold standard, which is the PCR.

Q. So in your view, would a antibody test that was positive constitute a confirmed case of COVID?

A. No. Because the other issue with the antibody test is we don't know, especially if the person had had travel history to China, it could be that it's a reaction from the previous SARS.

Q. And then in -- back into that paragraph 8, you talk about -- well, you say, "None of the

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02:38:17 call records or other documents or testimony
02:38:19 available provide evidence that any individual
02:38:23 displayed signs or symptoms of COVID-19 at a 24
02:38:26 Hour facility," right?
02:38:28 A. That's correct.
02:38:29 Q. Okay. But even if there was information
02:38:33 like that, in your opinion, that would not be
02:38:35 sufficient because those symptoms could have been
02:38:38 from other illnesses, correct?
02:38:41 A. That is correct. And we don't have
02:38:43 confirmation that it was COVID.
02:38:44 Q. Right.
02:38:45 And then you wrote, "The March 2020 call
02:38:50 records provided by Jeremy Gottlieb, subsequent
02:38:54 e-mails from Dan Larson, and other information
02:38:56 submitted by 24 HOUR do not include sufficient
02:38:59 evidence to indicate that individuals with
02:39:01 COVID-19 infections were at 24 HOUR facilities."
02:39:06 And that's because they don't include PCR
02:39:10 test results, correct?
02:39:12 MS. MANZO: Objection to form.
02:39:14 A. It's not only that. It's more than just
02:39:16 that PCR test results that aren't there. There's
02:39:19 not the chain of events that you'd want to know.
02:39:23 Just because Bob had COVID on Monday and he was

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02:39:27 at the facility on Friday doesn't mean that we
02:39:29 need to close the facility or do anything because
02:39:35 on Friday Bob probably wasn't contagious.
02:39:40 Q. So not only do you need the PCR test but
02:39:42 you also need more information about Bob's
02:39:46 illness and his whereabouts and those sorts of
02:39:48 things, correct?
02:39:49 A. Correct. And Dr. Carnethon refers to
02:39:51 this as temporality, which is part of the
02:39:53 Bradford Hill criteria. However, this is not a
02:39:57 causation case, so I didn't use -- I used
02:40:01 elements of Bradford Hill, but I don't use the
02:40:02 whole thing like she did. But that temporality
02:40:05 is really important because if you were in the
02:40:07 facility two weeks ago and then tests positive,
02:40:09 it doesn't matter.
02:40:14 Q. And then when you say "Such data would
02:40:16 have been available for any actual COVID-19 cases
02:40:19 because other businesses collected it at the
02:40:22 time," when you say actual COVID cases, you mean
02:40:26 cases where there was a positive PCR test?
02:40:31 A. Yes. What other businesses were doing at
02:40:34 this time were setting up sort of this triage
02:40:37 phone system to go through and asking questions,
02:40:42 hey, Bob called in, he's sick. Okay. Did you

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02:40:44 ask him did he get tested? If he got tested,
02:40:46 where did he get it tested? Was it a home kit?
02:40:48 There wasn't really home at this point. But did
02:40:50 he get it as his doctor's office? Where did he
02:40:52 go? When did he get the results versus when he
02:40:55 called us?
02:41:02 Q. Okay. And you understand that some of
02:41:03 the people that were either calling 24 Hour or
02:41:08 had told them that -- otherwise that they had
02:41:11 symptoms of illness were customers of 24 Hour
02:41:14 Fitness, right?
02:41:16 A. They had both customers and employees
02:41:18 calling in.
02:41:19 Q. And setting aside employees for a second,
02:41:23 do you agree that there would be no way for 24
02:41:25 Hour Fitness to mandate a customer to go get
02:41:29 tested?
02:41:30 MS. MANZO: Objection to form.
02:41:32 A. What 24 Hour can say is, did you have a
02:41:35 test?
02:41:36 Q. Right.
02:41:39 A. And where did you have that test done?
02:41:46 Q. And the customer could say none of your
02:41:48 business, right?
02:41:52 A. I would say it depends on the

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02:41:54 jurisdiction, because I will tell you having
02:41:57 worked with our city health department in New
02:41:59 Orleans, that would not have flown.
02:42:06 Q. But you don't know about other cities,
02:42:09 correct?
02:42:10 A. I knew some about what other cities were
02:42:11 doing because I am an active member of CST.
02:42:13 Q. Okay. Did you do any work to look at the
02:42:17 cities where 24 Hour Fitness operated to see what
02:42:21 the rules were about whether people had to
02:42:25 divulge their COVID status if requested by a
02:42:29 business?
02:42:32 A. I did not look for rules.
02:43:07 Q. With respect to your opinion about what
02:43:17 other businesses were doing in terms of
02:43:18 collecting information and doing contact tracing,
02:43:22 are you able to identify by name which businesses
02:43:27 you're talking about?
02:43:30 A. So I can tell you the government
02:43:32 recommendations were places like restaurants had
02:43:35 to have -- collect that information because
02:43:38 people were coming in and sitting down without
02:43:40 face coverings or -- and not necessarily always
02:43:44 spaced depending on the location, but most of the
02:43:48 states were requiring that.

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02:57:12 Q. In the spring of 2020 -- well, between
02:57:17 January through March of 2020, it was pretty rare
02:57:22 for people with no symptoms to be tested for
02:57:25 COVID, wasn't it?
02:57:29 A. If you were doing a field investigation,
02:57:31 you would maybe do that. But for the general
02:57:33 population, it would require normally
02:57:35 symptomatology to go to the doctor.
(Exhibit 9, New York Times article, It's Just Everywhere Already: How Delays in Testing Set Back the U.S. Coronavirus Response, marked for identification.)
02:58:29 Q. All right. So I marked as Exhibit 9 a
02:58:37 printout of a New York Times article from
02:58:39 March 10, 2020, and I know you talked earlier
02:58:42 about the New York Times, but I wanted to get
02:58:47 your view on something here. The article is
02:58:49 called "It's Just Everywhere Already: How Delays
02:58:54 in Testing Set Back the U.S. Coronavirus
02:58:57 Response."
02:58:59 And on the first page, the fourth
02:59:04 paragraph from the bottom, it says, "Even now,
02:59:08 after weeks of mounting frustration toward
02:59:11 federal agencies over flawed test kits and
02:59:14 burdensome rules, states with growing cases, such

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02:59:18 as New York and California, are struggling to
02:59:21 test widely for the coronavirus. The continued
02:59:24 delays have made it impossible for officials to
02:59:26 get a true picture of the scale of the growing
02:59:29 outbreak which has now spread to at least 36
02:59:32 states and Washington, D.C."
02:59:37 Do you agree with the author here that
02:59:42 there were problems during this time period
02:59:45 regarding the ability to test widely for
02:59:47 COVID-19?
02:59:51 MS. MANZO: Objection to form.
02:59:55 A. What I can say is that as one of the
03:00:05 criticisms that former epidemic intelligence
03:00:08 officers have had with CDC during this time frame
03:00:13 is that for some reason it became very political
03:00:17 and it became very difficult to work with the CDC
03:00:24 if you were a state health department.
03:00:30 The issue of testing is really dependent
03:00:34 on the location of the country you were in.
03:00:37 There are parts of the country that had no
03:00:40 problems with getting tests and it was very easy
03:00:43 to get a test. There were some locations within
03:00:45 the United States that it was more difficult to
03:00:47 get a test due to the number of cases that were
03:00:51 being seen, but also by sort of the rules that

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03:00:58 were associated with the test that you had to
03:01:00 have these symptoms in order to have the test
03:01:04 done.
03:01:04 Q. Okay. Do you agree with the author that
03:01:07 New York and California were areas where it was
03:01:11 difficult to do a widespread testing for COVID?
03:01:19 A. So I disagree with that some, but I have
03:01:21 insider knowledge. I worked very closely with
03:01:24 Los Angeles County on their testing and how they
03:01:27 set up their testing screens. So I disagree with
03:01:32 some of this, and also, there's no specificity.
03:01:36 I'm assuming they're meaning New York City
03:01:37 because I know people in other cities within New
03:01:40 York state that were able to get tested and had
03:01:43 no problems.
03:01:46 Q. And are you able to talk about the inside
03:01:48 knowledge that you're referring to with respect
03:01:50 to Los Angeles?
03:01:51 A. Well, I work for the county, and I've
03:01:53 evaluated their testing program several times
03:01:55 since the beginning of the pandemic and that's
03:01:58 about all I can share.
03:02:02 Q. Okay. So let's look at the next one.
(Exhibit 10, March 17, 2020 LA Times article, marked for identification.)

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03:02:36 Q. So Exhibit 10 is a Los Angeles Times
03:02:40 article from March 17th, 2020, and it's titled
03:02:47 "Newsletter: How You Can Slow Coronavirus'
03:02:50 Spread."
03:02:51 But I wanted to focus on -- let's see --
03:03:05 on page 2 of 9 at the bottom. There's a
03:03:13 question, "Will testing finally ramp up?" And it
03:03:17 says, "The lack of widespread testing early on in
03:03:20 the U.S. has made it nearly impossible to track
03:03:24 the coronavirus and ultimately forced the closure
03:03:27 of schools and businesses in many cities
03:03:29 nationwide. As of Monday the U.S. had tested
03:03:33 roughly 40,000 people for the virus while South
03:03:37 Korea, a country six times smaller, had tested
03:03:40 more than 260,000."
03:03:42 Do you see that?
03:03:43 A. I do.
03:03:54 Q. Do you believe that those statistics are
03:03:57 generally accurate, that comparing how many
03:04:01 people the U.S. had tested versus how many people
03:04:05 had been tested in South Korea?
03:04:09 A. I'm not sure this is accurate, so I can't
03:04:12 comment on a newspaper article such as this.
03:04:19 Q. Okay. Do you agree that the lack of
03:04:22 widespread testing was a reason for the closure

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03:04:27 of schools and businesses in many cities?
03:04:31 A. No. And I will also say that CDC's
03:04:33 retrospective analysis did not find that lack of
03:04:36 testing was the big issue.
03:04:40 Q. Okay. But at the time that the schools
03:04:42 and businesses were closed, do you agree that one
03:04:46 of the reasons was that because there wasn't
03:04:49 enough testing to determine who had COVID?
03:04:54 MS. MANZO: Objection to form.
03:04:56 A. No. And I think that's a fallacy if
03:04:58 that's the assumption being made in terms of how
03:05:00 epidemiologists would -- would -- would view
03:05:03 this?
03:05:06 Q. Okay. Why so?
03:05:11 A. Well, as an epidemiologist, the closure
03:05:20 wasn't because we didn't know if Bob or Mary or
03:05:23 Sue had COVID. The closure was done to help
03:05:27 prevent the spread of the virus throughout the
03:05:31 United States so that our health care resources
03:05:34 could catch up to what was needed.
03:05:38 And by closing and doing the stay at home
03:05:42 or safer at home or whatever the location is that
03:05:45 you're living in called those orders, those
03:05:49 orders went into effect at the recommendation of
03:05:53 federal agencies so that our health care

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03:05:56 resources could catch up and we didn't have
03:05:57 people on ventilators in hallways and we were
03:06:01 able to provide them what they needed.
03:06:04 What I will also tell you is that we know
03:06:09 based on how the spread of the virus happened in
03:06:13 the United States that locations that had travel
03:06:19 in and out of those locations and large
03:06:21 gatherings were some of the bigger drivers of
03:06:25 these cases and spikes in cases.
(Exhibit 11, "Antibodies to Severe Acute
Respiratory Syndrome Coronavirus 2
03:06:27 (SARS-CoV-2) In All of U.S. Research Program
03:07:10 Participants, 2 January to 18 March 2020,"
03:07:24 marked for identification.)
03:07:25 Q. Exhibit 11 is an article titled
03:07:30 "Antibodies to Severe Acute Respiratory Syndrome
03:07:33 Coronavirus 2 (SARS-CoV-2) In All of U.S.
03:07:38 Research Program Participants, 2 January to 18
03:07:42 March 2020."
03:07:45 This is an article that was cited by you
03:07:48 in your report, correct?
03:07:50 A. It's actually an article that was cited
03:07:52 by Dr. Carnethon, and I responded to the article
03:07:54 in my report.
03:07:58 Q. Okay. And would you consider this

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03:08:01 article to be a scientific article?
03:08:04 A. It's a journal article. There are some
03:08:06 issues with it, and I'm happy discuss those as we
03:08:10 proceed.
03:08:12 Q. In the beginning, in the Background
03:08:13 section it says, "With limited severe acute
03:08:19 respiratory syndrome, coronavirus (SARS-CoV-2)
03:08:22 testing capacity in the United States at the
03:08:25 start of the epidemic, January to March 2020,
03:08:30 testing was focused on symptomatic patients with
03:08:32 a travel history throughout February obscuring
03:08:36 the picture of SARS-CoV-2 seeding and community
03:08:39 transmission."
03:08:40 Do you see that?
03:08:44 A. I do.
03:08:44 Q. Do you disagree with that statement?
03:08:45 A. Yes.
03:08:48 Q. And why do you disagree with that?
03:08:50 A. Because this obscuring the picture of
03:08:53 SARS covariant-2 seeding and community
03:08:55 transmission piece of that sentence I disagree
03:08:58 with. And the more you go into the study you
03:09:01 realize that out of the 24,000 -- what is it? --
03:09:07 it's 24,500-ish -- about 24,079 study
03:09:20 participants, only two of those study

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03:09:24 participants were really people with symptoms.
03:09:27 Seven of them were really zero positive prior to
03:09:35 all of this. And we know that they were
03:09:38 associated with travel.
03:09:41 So using this to say that it was spread
03:09:43 through all across the United States was wrong.
03:09:46 We know that it was hitting large major
03:09:49 metropolitan areas where there was increased
03:09:52 travel in and out of those locations, and it's
03:09:55 not necessarily travel related to China or to
03:09:58 Italy or those locations. It was where people
03:10:01 are coming from one location where there was SARS
03:10:04 covariant to circulating among the population and
03:10:08 you had confirmed COVID-19 places into locations
03:10:14 where it didn't.
03:10:15 And if you look at the pattern of what
03:10:18 SARS covariant-2 did, in certain parts of the
03:10:21 country it took a while to get there. So the
03:10:25 assumption that's made in this paper, I think
03:10:30 it's great research, I think the assumptions are
03:10:33 wrong. And that's okay as a scientist for me to
03:10:36 say I don't agree with somebody else's research,
03:10:38 that happens all the time.
03:10:41 Q. Do you agree with the first part of what
03:10:45 I read, that about limited testing capacity in

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03:10:52 the U.S. at the start of the epidemic and that
03:10:55 testing was focused on symptomatic patients with
03:10:57 a travel history throughout February?
03:11:04 A. What I will say is that parts of this
03:11:10 were correct, that we limited our testing,
03:11:13 especially through February, to people who had
03:11:16 symptoms, which made the most sense when you have
03:11:21 a limited number of primers that are available
03:11:24 while you're making more to limit it to people
03:11:27 who are sick.
03:11:30 Q. And do you also agree that it was limited
03:11:33 to patients with a travel history?
03:11:39 A. I can't answer because I only know what
03:11:42 my state did, and I know what other states did.
03:11:47 And some states limited it to travel history,
03:11:49 others did not, because they looked at if people
03:11:53 had been to mass gatherings and that was another
03:11:55 part of this that's not mentioned in this
03:11:57 article.
(Exhibit 12, CSTE Interim-20-ID-01 Title: Standardized surveillance case definition and national notification for 2019 novel coronavirus disease, marked for identification.)
03:12:43 Q. Do you recognize Exhibit 12?

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03:13:01 A. I do.
03:13:01 Q. Okay. What is that?
03:13:03 A. This is the CSTE case definition document
03:13:07 from April of 2020 that was adopted by CDC. This
03:13:15 actually was worked on and created a little
03:13:20 earlier than that.
03:13:24 Q. So if you turn to page 6 at the bottom
03:13:35 under Revision History --
03:13:37 A. Yes.
03:13:37 Q. -- it says, "This is the first
03:13:39 standardized surveillance position statement for
03:13:42 COVID-19 and SARS-CoV-2 infection."
03:13:45 Do you see that?
03:13:46 A. That is correct.
03:13:47 Q. And what do you understand that to mean?
03:13:49 A. So this is the official position
03:13:53 statement that was released in April of 2020, at
03:14:00 the very first part of April, on COVID-19 cases,
03:14:11 which is the disease caused by SARS covariant-2,
03:14:15 and I think it's important on this one to know
03:14:19 that there was a working definition prior to
03:14:21 that -- prior to this because we had cases as
03:14:24 early as February and January.
03:14:27 This is the finalized case -- interim
03:14:29 case definition because they're going to continue

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03:14:32 to update this over time once we know more about
03:14:35 the virus.
03:14:45 Q. And is this the document that sets out
03:14:49 the criteria for a case of COVID-19 as you
03:14:53 discussed in paragraph 29 of your report that we
03:14:57 looked at before?
03:14:58 A. It's one of the documents, and then CSTE
03:15:01 or CDC had MMWRs where they were publishing
03:15:04 preliminary case definitions that CSTE was coming
03:15:09 up with.
03:15:09 Q. When were those MMWRs published?
03:15:11 A. They were being published as early as
03:15:13 January after our first travel-related cases.
03:15:16 Q. Were those published on the CDC website?
03:15:18 A. They can be, yes, and end up -- it's a
03:15:21 Morbidity and Mortality Weekly Report. We
03:15:24 were -- there were testing of people that were
03:15:30 related to travel exposures that were going on.
03:15:35 There was -- CSTE was working on their case
03:15:40 definition with CDC, and there was a preliminary
03:15:43 case definition that was used in those reports
03:15:46 because I couldn't capture a case if I didn't
03:15:48 know what it was.
03:15:49 Q. Okay. Do you know if those preliminary
03:15:51 case definitions were published by CDC on its

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03:15:55 website?
03:15:55 A. They would have been within Morbidity and
03:15:58 Mortality Weekly Report, the MMWRs, and the MMWRs
03:16:02 are published to the website.
03:16:07 Q. So do you agree that in order to have
03:16:10 found them, you would have had to know what you
03:16:12 were looking for?
03:16:13 MS. MANZO: Objection to form.
03:16:15 A. You would have to have somebody who knew
03:16:17 what they were doing to find those.
03:16:56 Q. Do you agree that in March 2020 and
03:17:02 before there were more people in the U.S. with
03:17:05 COVID-19 than there were people who had confirmed
03:17:10 positive cases of COVID-19 pursuant to the CSTE
03:17:15 case definition?
03:17:20 A. What I can say is not we had more than
03:17:26 likely circulating in certain populations in a
03:17:30 very localized manner cases of COVID-19 and those
03:17:36 would have been locations such as Seattle, Los
03:17:40 Angeles and New York City.
03:17:42 Biogenetically what came into New York
03:17:44 City was different than what was coming
03:17:46 biogenetic -- coming in on the West Coast. So we
03:17:50 know that we had two different populations with
03:17:54 two different strains, so to speak, of COVID that

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were coming in.
Would there have been potentially more cases during that time that were travel related that didn't get caught even though we had quarantine officers at those locations, there's always that risk. That outside of those locations it was not circulating rapidly in places like Austin or Dallas unless there was travel back and forth.
Q. I mean, you would agree generally that not everybody in the U.S. who had COVID-19 during March 2020 and before actually got a COVID-19 test, correct?
A. We know that there may have been an undercounting of the number of cases that were circulating in the population because of the criteria that was used to test people and it was that travel-related criteria. We probably missed household transmission, and in fact, that's one of the retrospective things that CDC has come back and said, hey, we missed some household transmission cases here. And we know that there were probably some underrepresentation of cases, as I said, in these large areas. We know we're having an influx of cases related to travel.

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Q. Let's go back to your report, which we marked as Exhibit 6. And if we could take a look at paragraph 12.
A. Paragraph 12. Sorry.
Q. In the first sentence of paragraph 12 you write, "There are an estimated 1 times 10 to the 31 viruses in the world," correct?
A. That's correct.
Q. And what point were you trying to convey by including that information?
A. What I'm trying to include in this is that the universe of viruses is quite large. We know that they're ubiquitous in the environments where people are, and we know that there are -- they're circulating at an endemic level, which means it's low-level throughout those populations, and it's important that we recognize that.
(Exhibit 13, Chemical Engineering Journal article, "Make it clean, make it safe: A review on virus elimination via adsorption," marked for identification.)
Q. So Exhibit 13 is an article from Chemical Engineering Journal from 2021 called "Make it clean, make it safe: A review on virus

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elimination via adsorption."
And I'll represent that this was an article that was cited by Dr. Sauer-Budge in her report.
Have you seen this article before?
A. I saw it in 2021, and I have not reviewed it since then, and so I probably need 15 to 20 minutes to review this.
Q. Okay. All right. Let me see if I can short circuit something. Well, in the introduction it says, "Viruses are ubiquitous in nature and consequently their interactions with superior organisms and human beings are constant."
That's basically what you just testified to, correct?
A. That they're everywhere.
Q. Okay. And so you would expect there to be viruss in this room right now, wouldn't you?
A. I would expect that, and I think we want to be really careful when we talk about viruses, whether we're talking about intact virus or we're talking about viral fragments. I would expect in this room to find all sorts of viral fragments because we've all been -- we went out to lunch,

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we came back in, we were in places where we may have had exposure to people who had other viruses. It sticks on our clothing. It comes in as a viral fragment.
So I think we want to be clear about intact virus versus viral fragments, and we're going to find viral fragments everywhere because viruses on a whole are ubiquitous.
Q. Okay. And would you think that you would more likely find intact virus in this room of one type or another?
A. So I'm not going to ask personal questions of people, but, you know, if we were talking about something like hepatitis B, if somebody is hepatitis B positive and they're shedding the virus, it's going to stick around on surfaces a lot longer than something like HIV. And that's why in the early days before we could really test for HIV, we were actually testing for Hep B and using it as a surrogate marker because people at the time were typically coinfected.
Now we have a marker for HIV, but we still know that it's -- that hepatitis B sticks around for a lot longer. Hepatitis A is one that we know is everywhere and it sticks around and

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03:37:59 Q. All right.
03:37:59 A. But they stamped it as 2022.
03:38:03 Q. And in the fall of 2021, when it was
03:38:07 published, did you believe that the information
03:38:10 in here was accurate?
03:38:14 A. Yes. And you can see even if you go to
03:38:16 Disinfectants For SARS Covariant-2 paragraph, you
03:38:20 can see when we wrote it versus when it actually
03:38:22 got stamped with a date, because this was as of
03:38:25 June 2nd, 2021.
03:38:27 Q. Okay. And as of that time, you believed
03:38:31 that the information in here was accurate?
03:38:33 A. It was based on what we knew at the time,
03:38:40 and we knew that -- and this was sort of
03:38:48 information that we knew. This was also based
03:38:50 sort of on what CDC was putting out in that 2021
03:38:54 time frame.
03:38:57 Q. Okay. Have you considered whether there
03:39:02 should be any update to this?
03:39:11 A. I mean, here's the thing, CDC -- and I
03:39:17 agree as an epidemiologist on one of the points
03:39:20 that CDC is making and they made this even in
03:39:23 April of 2021, if I immediately sneeze or cough
03:39:27 on a surface and immediately someone touches
03:39:30 their hand to it and then touches their eyes,

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03:39:32 mouth or nose, are they more likely to probably
03:39:35 get the virus that way? We don't know. But it's
03:39:37 more likely to happen than come back 15 minutes
03:39:40 later and do it.
03:39:42 So the information in here is still very
03:39:46 valid, and we know that this issue of good
03:39:55 hygiene prevented some really bad flu seasons,
03:39:57 too, so we're going to encourage people to
03:39:59 continue to do that.
03:40:01 What the purpose of this paper was really
03:40:03 to talk about one thing that's been overlooked in
03:40:10 this, is the toxicity of the cleaners that we're
03:40:12 using to clean for the virus or disinfect from
03:40:14 the virus and what they have on the population of
03:40:16 people who are using them.
(Exhibit 15, Scientific Brief: SARS-CoV-2 Transmission, marked for identification.)
03:41:30 Q. Do you recognize Exhibit 15, which is
03:41:36 published by the CDC titled "Scientific Brief:
03:41:40 SARS-CoV-2 Transmission," updated May 7th, 2021?
03:41:45 And I believe this is in your report at footnote
03:41:49 38.
03:41:50 A. It is. And the companion to this one,
03:41:52 just for clarification, is you really need to
03:41:55 look at the April 2021, one specific on fomite

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03:41:59 and this one and put them together because this
03:42:02 one keeps referring back to that one.
03:42:05 Q. All right. Why don't we look at that
03:42:21 one, too.
(Exhibit 16, Science Brief: SARS-CoV-2 and Surface (Fomite) Transmission for Indoor Community Environments, marked for identification.)
03:42:30 Q. And so Exhibit 16 is from the CDC, also
03:42:35 titled "Science Brief: SARS-CoV-2 and Surface
03:42:39 (Fomite) Transmission for Indoor Community
03:42:41 Environments," updated April 5th, 2021.
03:42:45 Is that the one that you just referenced?
03:42:47 A. Yes. And they have not updated it since
03:42:49 then because this is still pretty much the same
03:42:52 current science as what we have now. And if you
03:42:56 look at the May one, you have to go back to this
03:42:58 one because they refer back to it a couple of
03:43:00 times.
03:43:00 Q. All right. And so if you look at
03:43:18 Exhibit 15, this is from the May 2021 document,
03:43:27 there's a section in the middle of the page,
03:43:30 "Transmission of SARS-CoV-2 From Inhalation of
03:43:33 Virus in the Air Farther Than 6 Feet From an
03:43:36 Infectious Source Can Occur."

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03:43:38 Do you see that?
03:43:39 A. I do.
03:43:42 Q. Okay. And at the bottom of that
03:43:47 paragraph, the first full paragraph there it
03:43:49 says, "Per published reports, factors that
03:43:52 increase the risk of SARS-CoV-2 infection under
03:43:55 these circumstances include: (1) enclosed spaces
03:44:00 with inadequate ventilation or air handling,"
03:44:04 next, "Increased exhalation of respiratory fluids
03:44:10 if the infectious person is engaged in physical
03:44:14 exertion or raises their voice, e.g., exercising,
03:44:18 shouting and singing," and the next one is
03:44:22 "Prolonged exposure to these conditions,
03:44:24 typically more than 15 minutes."
03:44:26 Do you see all of that?
03:44:28 A. I do.
03:44:31 Q. And as you just stated, that this has not
03:44:33 been updated by the CDC since May of 2021?
03:44:38 A. No. Because we're finding the same
03:44:40 information. I mean, the risk of fomite
03:44:42 transmission is about 1 in 10,000, which is in
03:44:44 the April guidance. We knew that there's a
03:44:50 couple of different studies that went into this
03:44:54 transmission of SARS covariant-2 from inhalation
03:44:56 of virus in the air farther than 6 feet from an

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03:44:59 infectious source can occur.
03:45:01 I've already just talked about physical
03:45:03 exertion with that heavier breathing, singing.
03:45:07 We have one where in another case in Asia where
03:45:11 people were shouting at each other with no
03:45:13 ventilation in the room and they found that SARS
03:45:17 was forced that way.
03:45:18 But I think when we think -- and that
03:45:21 prolonged exposure information is coming from the
03:45:27 studies that were done and then prison guards and
03:45:30 prison transport of prisoners versus guard and
03:45:34 who had on a mask, who didn't have on a mask, and
03:45:37 how long they were in close contact with each
03:45:39 other.
03:45:40 But I think if we're talking about it, we
03:45:42 really have to go into that next paragraph that
03:45:44 says that we can prevent it if you wear good
03:45:48 barriers, like a face mask.
03:45:50 Q. Right.
03:45:58 And the one from April, Exhibit 16,
03:46:05 that's also cited in your report?
03:46:08 A. Yes, that's correct.
03:46:08 Q. All right. And if we go back to your
03:46:22 report, which was Exhibit 6, and we go to I think
03:46:30 it's paragraph 18 --

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03:46:31 A. Okay.
03:46:45 Q. -- that's where you cite these two CDC
03:46:49 documents, correct?
03:46:50 A. That's correct.
03:46:51 Q. All right. If we look at paragraph 19 --
03:48:30 A. Yes.
03:48:31 Q. -- you talk there about people who are
03:48:36 infected with SARS-CoV-2 being asymptomatic,
03:48:42 presymptomatic, or have mild symptoms of
03:48:45 COVID-19. And what was your thinking in terms of
03:48:51 talking about that issue?
03:48:55 A. So one of the things that there's a bit
03:48:57 of -- it wasn't misinformation, it was what was
03:49:02 known at the time based on two studies that
03:49:04 weren't that well designed were pinning the rates
03:49:08 of asymptomatic at 80 percent. We really think
03:49:12 that that rate is closer to 15 percent and it's
03:49:15 not just asymptomatic alone.
03:49:17 It's asymptomatic plus presymptomatic
03:49:21 people or somebody who, like my husband when he
03:49:24 got COVID for the first couple days, I just -- I
03:49:28 think I'm getting a sinus infection and didn't do
03:49:30 anything about it to test for three days and then
03:49:32 he finally tested -- then he decides to test and,
03:49:35 of course, you know, it's two lines and he's

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03:49:37 really positive.
03:49:39 So my point of saying this is, look, we
03:49:43 know on the regular community, not in a nursing
03:49:46 home, that it's about 15 percent of the
03:49:48 population is either asymptomatic,
03:49:50 presymptomatic, or showing very mild symptoms.
03:49:54 Q. Okay.
03:49:54 A. And I think that's an important point
03:49:55 when were talking about surveillance.
03:49:59 Q. So during that period of time, and
03:50:01 apologies to your husband, that he thought he
03:50:06 might have had a sinus infection, if he had gone
03:50:09 out and gone to the store or gone to the gym or
03:50:14 been around other people, he could have infected
03:50:18 those people, correct?
03:50:22 A. So I made him e-mail his entire council
03:50:26 that he met with for his school during that time
03:50:29 and say, hey, I tested positive for COVID.
03:50:32 Nobody else got it. It was everybody's
03:50:34 vaccinated, so there were mitigation strategies.
03:50:37 They all work for a university. They all were
03:50:39 being very careful about what they did.
03:50:41 But I think in the early days we still
03:50:44 knew that you could have had these lower, smaller
03:50:47 symptoms, you could have had that, but we had

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03:50:51 effective strategies even dealing with it. Now
03:50:53 we're more relaxed than we were in 2020.
03:50:55 Q. Right.
03:50:55 But you were concerned enough about the
03:51:01 possibility that he could have spread it that you
03:51:03 did -- you made that contact.
03:51:07 A. Well, because it was three months ago, we
03:51:09 have no mask mandate, he stopped wearing a mask,
03:51:12 they're all meeting together and they're in an
03:51:13 enclosed space --
03:51:14 Q. Right.
03:51:15 A. -- and there's 15 of them sitting around
03:51:17 a table, so of course I made him do it.
03:51:19 Q. Yeah. And early -- if it had been early
03:51:24 March of 2020 and let's say he was in California
03:51:28 and he had gone to the same meeting with no mask
03:51:34 wearing, that also would have been a potential
03:51:37 exposure route, wouldn't it?
03:51:40 A. It could have been a potential exposure
03:51:43 route, but depending on what time in March, he
03:51:46 would have made the individual decision to wear a
03:51:51 mask or distance himself even from any of those
03:51:55 large groups. He shouldn't live with me because
03:51:58 I make him do all this stuff.
03:52:00 Q. Right.

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03:58:44 South Korea, which were different than they were here.
03:58:46
03:58:47 Q. Okay. But at the very least, as of that
03:58:56 spring 2020, early summer 2020 time period, this
03:59:05 reflects thinking in the scientific community
03:59:09 regarding the role of younger people in spreading
03:59:12 the virus even though maybe that later on the
03:59:17 information on that or data on that may have
03:59:20 changed; is that a fair statement?
03:59:21 MS. MANZO: Objection to form.
03:59:23 A. I think it's really hard to take one
03:59:25 article and say that that's kind of the body of
03:59:27 literature that's out there on it, and there had
03:59:29 been a couple. But those studies were really
03:59:34 done more in Asia than they are in the U.S., and
03:59:37 it's very hard, other than to understand kind of
03:59:40 disease morphology and those pieces to it, that
03:59:46 what you see in Asia is going to hold true in the
03:59:49 U.S.
03:59:49 And there's a couple of reasons for that.
03:59:51 One is they used a totally different test than we
03:59:53 used. They weren't using the same PCR testing
03:59:55 that we were. We don't know how good their
03:59:59 primer is. We don't know how effective their
04:00:00 test was in picking up those cases.

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04:00:03 So we put this into that body of
04:00:07 literature that said that we probably had a very
04:00:11 high asymptomatic rate. We now know that wasn't
04:00:13 true, but we were really worried about it in May.
04:00:23 Q. And that worry about it in May is
04:00:35 reflected in the PowerPoint that you presented in
04:00:39 around that time period, correct?
04:00:41 A. I'll be honest, I was terrified. We had
04:00:44 a -- I had a workforce that I was worried about,
04:00:46 and I had all these clients that were depending
04:00:48 on me not to screw it up and bring COVID to their
04:00:50 places. I probably slept less in the first parts
04:00:55 of COVID than I did when I was working at CDC or
04:00:58 having small children.
04:00:59 Q. And then going back to your report,
04:01:05 Exhibit 6, in paragraph 20 you talk about the
04:01:12 American society of heating, refrigeration, and
04:01:15 air conditioning, that's ASHRAE, correct?
A. (Nodding head up and down.)
04:01:20 Q. And you talk about their guidelines to
04:01:27 reduce airborne infectious aerosol exposures.
04:01:31 What was the purpose that you wanted -- well,
04:01:35 what was your purpose for citing to that in your
04:01:37 report?
04:01:39 A. Because we know that ASHRAE had really

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04:01:44 good data out there early on, on things that you
04:01:49 could do to potentially reduce the spread in your
04:01:51 business or your operations by increasing your
04:01:56 air filtration systems and also by your air
04:01:59 exchange rates.
04:02:02 And they also had some decent guidance on
04:02:04 how to put up barriers and where you should put
04:02:06 those barriers up so that you're not making
04:02:09 things worse.
(Exhibit 18, ASHRAE Epidemic Task Force, Core Recommendations for Reducing Airborne Infectious Aerosol Exposure, marked for identification.)
04:02:23 Q. So Exhibit 18 is titled "ASHRAE Epidemic
04:03:04 Task Force, Core Recommendations for Reducing
04:03:09 Airborne Infectious Aerosol Exposure."
04:03:12 And I guess my first question is, is
04:03:15 this -- are these the guidelines that you're
04:03:17 referring to in your report?
04:03:20 A. These are part of them. And early in the
04:03:23 pandemic they had a very large packet you could
04:03:26 download from their website that had more
04:03:31 guidance than this. This was sort of the take
04:03:34 away guidance from it. But...
04:03:36 Q. Okay. Do you recall at what point in the

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04:03:43 pandemic those materials were made available?
04:03:46 A. March and April.
04:03:47 Q. Okay.
04:03:47 A. They had put out a very large packet of
04:03:50 information early on. And we were referring our
04:03:53 clients to it.
04:03:54 Q. Okay. Great.
04:04:00 A. And it was a really nice packet, too. It
04:04:02 had all the technical reasoning behind it.
04:04:26 Q. In paragraph 21, which talks about
04:04:34 fomites, you have a sentence that says, "To date,
04:04:38 there are no known confirmed cases of fomite
04:04:41 transmission of the SARS-CoV-2 virus."
04:04:48 How would a case of fomite transmission
04:04:50 of the virus be confirmed --
04:04:53 MR. WEISS: Well, strike that.
04:04:58 Q. How could you even tell whether somebody
04:05:00 got COVID from fomites versus some other way?
04:05:04 A. It tends to be a process of elimination.
04:05:07 I mean, I use SARS covarient-1 as the example of
04:05:12 this. There is one study, it's either Singapore
04:05:17 or Hong Kong and I'm pretty sure it was Hong
04:05:18 Kong, that was done in an apartment complex, and
04:05:23 the only thing that we could identify that these
04:05:27 two individuals had in common was the elevator

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04:17:02 Q. No, you should. They're interesting.
04:17:05 If we could go back to your report in
04:17:10 paragraph 36.
04:17:13 A. Okay.
04:17:14 Q. And let me go to where I wanted to go to.
04:17:25 You wrote, "Dr. Carnethon argues that testing
04:17:29 underrepresented the number of true cases of
04:17:32 COVID-19 in the population in March and April of
04:17:36 2020 and asserts that cases were widespread and
04:17:38 could not be counted due to the lack of readily
04:17:41 available tests. CDC in May of 2020 conducted an
04:17:47 analysis of why the spread occurred quickly in
04:17:49 March and April of 2020 and did not determine
04:17:52 that the lack of testing was a factor in how
04:17:56 cases were counted and spread."
04:17:59 Did I read that correctly?
04:18:01 A. You did.
04:18:01 Q. All right. So let's look at 31.
(Exhibit 19, "Public Health Response to
the Initiation and Spread of Pandemic COVID-19
in the United States, February 24 - April 21,
2020, marked for identification.)
04:18:17 Q. Is this the article that you cited in
04:18:34 your report for the proposition that the CDC
04:18:39 conducted an analysis and did not determine that

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04:18:44 the lack of testing was a factor? I think it's
04:18:46 in footnote 70 of your --
04:18:48 A. Yes.
04:18:49 Q. Okay. At the bottom of the first column
04:18:55 of page 1 of the exhibit it says, "Factors that
04:19:00 contributed to the acceleration of dissemination
04:19:04 in March included," and number 4 is, "Challenges
04:19:10 in virus detection, including limited testing,
04:19:14 emergence during the peak months of influenza
04:19:17 circulation and influenza and pneumonia
04:19:19 hospitalizations and other cryptic transmission,
04:19:23 including from persons who are asymptomatic or
04:19:26 presymptomatic."
04:19:29 A. Yes.
04:19:29 Q. So doesn't that say that the CDC was
04:19:34 including challenges in testing and limited
04:19:38 testing as a factor in the spread of the virus?
04:19:41 A. So one of the things they're really
04:19:42 focusing on, and if you go back and read through
04:19:45 this, is really this issue of cryptic cases. So
04:19:49 there were -- and I've not said there's not been
04:19:53 isolated cases of limited testing. There are.
04:19:58 But we can't take that and apply it globally to
04:20:00 the entire population that was here.
04:20:03 And, you know, I think if you go in and

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04:20:09 read the little discussion and all the rest of
04:20:12 the pieces of this, I'm still saying the same
04:20:16 thing they are saying here with the cryptic
04:20:19 testing, so...
04:20:20 And I even go on to say, you know, "while
04:20:27 testing in some locations may have been an issue,
04:20:30 many state and local health departments recognize
04:20:32 the same issues documented by CDC in their
04:20:34 retrospective article and took steps to reduce
04:20:37 spread through stay-at-home orders and
04:20:40 surveillance with robust contact tracing to
04:20:42 reduce spread to compensate for the lack of
04:20:44 readily available tests."
04:20:48 Q. What is cryptic transmission?
04:20:51 A. Unrecognized transmission. We don't know
04:20:53 how it's happening. And where -- where we have
04:20:57 these little clusters of cases and we don't quite
04:21:00 understand it.
04:21:02 Q. So they may not be tied to somebody who
04:21:03 traveled to China, for example, or...
04:21:07 A. Not necessarily. Or here's a good
04:21:09 example. You come in, you're doctor tests you
04:21:12 only for influenza. That we know now and after
04:21:17 the 2021 flu season, we now know to test
04:21:21 everybody who comes in for both flu and COVID

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04:21:24 because what we're doing is just saying, oh, it's
04:21:26 only influenza and sending you home when you
04:21:28 could have had both influenza and COVID.
04:21:35 The other big issue that we were having
04:21:39 at that time, you have to remember, is RSV, and
04:21:46 RSV was running rampant as far as 2020 and it
04:21:51 still is such a big deal today.
04:21:54 Q. Looking back at Exhibit 19 in the first
04:21:58 paragraph, at the end it says -- or towards the
04:22:05 end it says, "By mid March transmission of
04:22:09 SARS-CoV-2, the virus that causes COVID-19, had
04:22:12 accelerated with rapidly increasing case counts
04:22:16 indicating established transmission in the United
04:22:18 States. Ongoing traveler importation of
04:22:23 SARS-CoV-2 attendance at professional and social
04:22:27 events, introduction into facilities or settings
04:22:31 prone to amplification, and challenges in virus
04:22:34 detection all contributed to rapid acceleration
04:22:37 of transmission during March."
04:22:39 Do you see that?
04:22:41 A. I do.
04:22:41 Q. And you don't disagree with that
04:22:44 statement, do you?
04:22:45 A. No. And I haven't disagreed with it in
04:22:46 the report.

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04:22:47 Q. All right.
04:23:22 MR. WEISS: I think I'm done with my
04:23:24 questions. So thank you so much for your time.
04:23:27 Hopefully I didn't mess you up by not taking a
04:23:30 flight tomorrow, but...
04:23:32 THE WITNESS: You have not, and thank you
04:23:33 for being kind because the last depo I had last
04:23:37 week, I really had somebody screaming in my face.
04:23:40 So thank you.
04:23:41 MR. WEISS: Oh, I hope that's on the
04:23:43 record.
04:23:45 Deanna, do you have follow-up or anybody
04:23:46 else?
04:23:48 MS. MANZO: I do not have any follow-up.
04:23:50 MR. WEISS: Anybody on Zoom? No.
04:23:54 Hearing no objections, I think we're -- we can
04:23:57 conclude.
04:23:59 THE VIDEOGRAPHER: Okay. The time is now
04:24:02 3:56. We are off the record.
(Whereupon, this deposition concluded at
3:56 p.m.)

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CERTIFICATE

Commonwealth of Massachusetts
Suffolk, ss.

I, Dana Welch, Registered Professional Reporter, Certified Realtime Reporter, do hereby certify that ALLISON STOCK, Ph.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me before the commencement of such deposition, and that such deposition was taken before me and is a true record of the testimony given by such witness.

I further certify that the adverse party was represented by counsel at the deposition. I further certify that I have no disqualifying interests, personal or financial, in any party in this action.

I further certify that the deposition of ALLISON STOCK, Ph.D., occurred IN PERSON on AUGUST 22, 2023 in BOSTON, MASSACHUSETTS, commencing at 10:04 a.m. and concluding at 3:56 p.m.

____
Dana Welch, CSR, RPR, CRR
Notary Public
My Commission Expires:
September 13, 2024

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DEPOSITION ERRATA SHEET

Assignment No. J10132723
Case Caption: 24 Hour Fitness v. Continental Casualty, et al.

DECLARATION UNDER PENALTY OF PERJURY

I, ALLISON STOCK, Ph.D., declare under penalty of perjury that I have read the entire transcript of my deposition taken in the captioned matter or the same has been read to me, and the same i true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the ____ day of
________________, 2023.

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ALLISON STOCK, Ph.D.

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